Department of Vermont Health Access

DVHA 284B
R 10/10

Request For Extension of Rehabilitation Therapy Services

Please see instructions on reverse side

Name _____
Birth date _____
Medicaid ID # _____
Provider Agency _____
Medicaid Provider # _____
Attending Provider (MD) Name _____
Attending Medicaid Provider # _____

Dates or Events Complicating Therapy:
_____
_____
_____

Adherence to home program:
_____
_____

Diagnoses	Dates Of Onset
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Discipline: ☐ OT ☐ PT ☐ ST (check one)

Report Period	Objective, measurable, patient oriented goals and research-based treatment plan	Goals met/not met (circle one) (*If not met, state reason and provide objective parameters*)
First 4 months of treatment Date of initial therapy for this episode or condition: _____ Date 4 months after initial therapy _____ Treatment frequency_____ Procedure codes:_____ Time: _____	Goal 1 _____ Goal 2 _____ Goal 3 _____ Goal 4 _____ Treatment Plan (procedures): _____	Goal 1 met/not met _____ Goal 2 met/not met _____ Goal 3 met/not met _____ Goal 4 met/not met _____ Date _____ Therapist Signature _____
Second 4 months of treatment Date 4 mo + 1 day after initial therapy _____ Date 8 mo after initial therapy _____ Treatment Frequency _____ Procedure codes:_____ Time: _____ **MD Signature**_____ **Date:**_____	Goal 1 _____ Goal 2 _____ Goal 3 _____ Goal 4 _____ Treatment Plan (procedures): _____	Goal 1 met/not met _____ Goal 2 met/not met _____ Goal 3 met/not met _____ Goal 4 met/not met _____ Date _____ Therapist Signature _____
Third 4 months of treatment Date 8 mo + 1 day after initial therapy _____ Date 12 mo after initial therapy _____ Treatment Frequency _____ Procedure codes:_____ Time: _____ **MD Signature**_____ **Date:**_____	Goal 1 _____ Goal 2 _____ Goal 3 _____ Goal 4 _____ Treatment Plan (procedures): _____	Goal 1 met/not met _____ Goal 2 met/not met _____ Goal 3 met/not met _____ Goal 4 met/not met _____ Date _____ Therapist Signature _____

REQUESTS FOR EXTENSION OF REHABILITATION THERAPY SERVICES

INSTRUCTIONS FOR USE OF THE DVHA MEDICAID EXTENSION FORM

Physical, occupational and speech therapy services are routinely covered for 4 months on initial physician certification.

A written request by the practitioner to extend the period of treatment beyond the first 4 months must be submitted to the Department of VT Health Access at least 14 days prior to the expiration of the initial 4 month period or subsequent 4 month periods to avoid interruption of payment. **The request must include:**

- Beneficiary name, date of birth and Medicaid ID number
- Provider name and VT Medicaid provider number
- Name of attending physician and VT Medicaid provider number
- Adherence to home program
- Discipline (OT, PT, ST)
- Collaboration with school model services (under 21 only)
- Date of initial therapy
- Date and events complicating therapy that affect extension of Medicaid service, including hospitalization, trauma and illness
- Primary and other relevant diagnosis with dates of onset
- Initial and final dates of the previous 4 month period
- Treatment frequency during the previous 4 month therapy period
- Objective, measurable goals for the previous 4 month period
- Research based treatments/ procedures provided during the previous 4 month period
- Whether each goal was met or not met
- If goals were not met, an explanation of why they were not met and objective parameters for current results
- Initial and final dates of the upcoming 4 month period for which therapy is being requested
- Treatment frequency during the upcoming 4 month period
- Objective, measurable goals for the upcoming 4 month period
- Research based treatments/ procedures to be provided during the upcoming 4 month period
- Date & Therapists Signature with professional designation
- **Date & Signature of Physician**
- **Procedure codes to be used in billing for Therapy services** (private practice and hospital only)

This information can be provided by use of the extension form on the reverse side or by another form which contains all of the above information. A Medicare 700/701 form or HCFA 485-7 may be utilized, provided that any of the required information listed above that is missing from the form is added to it before it is sent to DVHA. Any additional attachments which further clarify the beneficiary's medical status and treatment are welcome.

FIRST SUBMISSION OF THIS FORM:
FILL OUT **COMPLETELY** 14 DAYS BEFORE INITIAL 4 MONTH PERIOD IS OVER:

- Top area of form with basic information
- Box 1, column 1 with information from the first 4 months of treatment
- Box 1, column 2 with goals and plan from the first 4 months of treatment
- Box 1, column 3 for current status
- Box 2, column 1 with information for the upcoming 4 months of treatment
- Box 2, column 2 with goals and plan for the upcoming 4 months of treatment

SECOND SUBMISSION OF THIS FORM:
FILL OUT **COMPLETELY** 14 DAYS BEFORE THE SECOND 4 MONTH PERIOD IS OVER:

- Box 2, column 3 for current status and results of treatment
- Box 3, column 1 with information for the upcoming 4 months of treatment
- Box 3, column 2 with goals and plan for the upcoming 4 months

THERAPY COVERAGE BEYOND ONE YEAR:
Medicaid rule 7401.4 states that "Prior authorization for therapy services beyond one year from the onset of treatment will be granted only:

- If the service may not be reasonably provided by the patient's support person(s), and
- If the patient undergoes another acute care episode or injury, or
- If the patient experiences increased loss of function, or
- If deterioration of the patient's condition requiring therapy is imminent and predictable

Please save a copy of this form for your records. The Medicaid copy can be sent to the DVHA at 312 Hurricane Lane, Suite 201, Williston, VT 05495 or faxed to (802) 879-5963. Please call (802) 879-6396 for questions regarding therapy, including inservicing, documentation and coverage. For PA status please call HP @ 1-800-925-1706 or (802) 878-7871.